| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155094 | A. BUILDING 01<br>B. WING | 06/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST MARY HEALTHCARE CENTER | 2201 CASON ST<br>LAFAYETTE, IN47904 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 06/01/11<br><br>Facility Number: 000037<br>Provider Number: 155094<br>AIM Number: 100291350<br><br>Surveyor: Bridget Brown, Life Safety Code Specialist<br><br>At this Life Safety Code survey, St. Mary Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and was fully | K0000 | Submission of this plan of correction does not constitute an admission by St. Mary Health Campus of any wrong doing or failure to comply with the Federal and State Regulations. St. Mary Health Campus submits this plan of correction as its letter of credible allegation and requests a survey revisit on or shortly after July 1, 2011. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | sprinklered. The facility has a fire alarm system with single station smoke detection in the corridors and spaces open to the corridors. Battery operated smoke detectors are located in resident rooms. The facility has the capacity for 70 and had a census of 63 at the time of this survey.<br><br>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/08/11.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by: | | | |
| K0017 SS=E | Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 | | | |

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| | Based on observation and interview, the facility failed to ensure a one half hour exit corridor separation for 1 of 3 dining areas was maintained during renovation construction. LSC 4.6.10.1 permits areas under construction may be occupied only where the required means of egress and fire protection features are in place and continuously maintained. LSC 7.1.3.2.1 requires exits shall be separated from other parts of the building by not less than one half hour construction in a sprinklered building. LSC 7.1.3.2.2 requires enclosures shall provide a continuous protected path of travel to an exit discharge. This deficient practice affects visitors, staff and at least 20 residents of the main dining room.<br><br>Findings include:<br><br>Based on observation with the maintenance director and administrator on 06/01/11 at 12:45 p.m., access to a southwest exit provided from the main dining room exposed occupants to the unprotected 100 hall corridor | K0017 | CORRECTIVE ACTIONThe 100 hall corridor including the dining room will be closed and will not be occupied by residents. The facility will add a door which will include the required fire protection features. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations (DPO) will ensure that residents are not able to pass through the construction zone. MONITORING CORRECTIVE ACTIONThe DPO will report all problems with residents entering the constuction zone to the QA Committee monthly x 6 months. | 07/01/2011 |

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| | which was undergoing renovation. Doors had been removed from rooms opening into the corridors, walls had been removed and openings in walls were made exposing electrical conduit. Smoke detectors were covered with plastic to prevent construction dust from setting off unintended alarms. The administrator said at the time of observation, the path of exit was kept "clear" but agreed there were no doors and walls in the construction smoke compartment to separate the exit path.<br><br>3.1-19(b) | | | |
| K0018 SS=E | Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br>Based on observation and | K0018 | CORRECTIVE ACTIONThe 100 hall corridor including the main | 07/01/2011 |

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| | interview, the facility failed to ensure a door provided separation from the exit corridor for 1 of 3 dining areas during renovation construction. LSC 4.6.10.1 permits areas under construction may be occupied only where the required means of egress and fire protection features are in place and continuously maintained. LSC 7.1.3.2.1 requires exits shall be separated from other parts of the building by not less than one half hour construction in a sprinklered building. LSC 7.1.3.2.2 requires enclosures shall provide a continuous protected path of travel to an exit discharge. This deficient practice affects visitors, staff and at least 20 residents of the main dining room.<br><br>Findings include:<br><br>Based on observation with the maintenance director and administrator on 06/01/11 at 12:45 p.m., access to a southwest exit provided from the main dining room exposed occupants to the unprotected 100 hall corridor which was undergoing renovation. Doors had been removed from | | dining room will be closed for resident use. The facility will add a proper door which will provide separation from the area under construction. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the deficient practice. MEASURES/SYSTEMIC CHANGESThe main dining rooom will be closed for resident use. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) will monitor that residents are not permitted in the construction zone and will report findings to the QA Committee monthly x 6 months. | |

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| | rooms opening into the corridors The administrator said at the time of observation, the path of exit was kept "clear" but agreed there were no doors in the construction smoke compartment to separate the exit path.<br><br>3.1-19(b) | | | |
| K0025 SS=E | Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br>Based on observation and interview, the facility failed to ensure openings through ceiling and wall smoke barriers in 5 of 5 occupied smoke compartments were protected with approved materials to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating | K0025 | CORRECTIVE ACTIONa. The main dining room will be closed for resident use. b. c. d. Annular opening near room 207, space near room 121, and space near dishwasher have been sealed to prevent penetration.IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice.MEASURES/SYSTEMIC CHANGESEntire facility is under renovations. All unsealed areas will be fixed immediately upon identification. MONITORING CORRECTIVE ACTIONThe | 07/01/2011 |

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| | item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 20 or more residents in north 100 hall, north, and center smoke compartments with a census of 54 residents.<br><br>Findings include:<br><br>Based on observations with the maintenance director and administrator on 06/01/11 between 12:25 p.m. and 3:40 p.m., smoke barrier penetrations were observed at:<br>a. The smoke barrier wall between the main dining room and adjacent smoke compartment wall had a 12 by 18 inch opening cut out and a partition constructed of untreated wood framing and plastic sheeting separated the main dining room from this smoke barrier opening and construction in an adjacent activity room and exit corridor. The administrator said at the time of observation, the partition was in place to | | Director of Plant Operations (DPO) or designee will monitor unsealed penetrations one time per week during renovations by communicating with general contractor the need to identify unsealed penetrations for repair. DPO will repair unsealed areas immediately. The DPO will report findings to the QA Committee monthly x 6 months. | |

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| | protect residents from construction dust in the adjacent areas.<br>b. A one inch unsealed annular opening around a four inch sprinkler pipe above the laid in ceiling near room 207;<br>c. The conduit penetration above the laid in ceiling near room 121 had a one inch section of unsealed space where fire caulk had fallen away;<br>d. A one inch gap around a pipe was unsealed where it penetrated the ceiling of the dishwashing area of the kitchen.<br>The maintenance director said at the time of observations, he was unaware of the unsealed penetrations.<br><br>3.1-19(b) | | | |

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| K0038 SS=E | Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br>Based on observation and interview, the facility failed to ensure egress for 2 of 2 exits was arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects all occupants of the 300 hall smoke compartments with a census of 29 residents.<br><br>Findings include:<br><br>Based on observation with the maintenance director and administrator on 06/01/11 between 12:20 p.m. and 3:40 p.m., the egress path for the 300 hall fire exit corridor was used as collection points for six unoccupied wheel chairs, two | K0038 | CORRECTIVE ACTIONThe facility rented additional storage and cleaned existing storage areas to accomodate storage items in the 300 corridor.<br>IDENTIFY OTHER RESIDENTS29 residents have the potential to be affected by the alleged deficient practice.<br>MEASURES/SYSTEMIC CHANGESStaff will be inserviced regarding problems associated with storage in the corridors and additional storage options.<br>MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will monitor 300 corridor storage 3 times per week x one month, and 1 time per week x five months. The DPO will correct storage concerns immediately. | 07/01/2011 |

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| | Hoyer lifts, and four medicine and treatment carts when not in use. The equipment was moved at times throughout the day with no change in the exit clearance by 3:40 p.m. on 06/01/11. The administrator said upon interview on 06/01/11 at 3:40 p.m., the area was used as a collection point because there was insufficient storage and leaving wheelchairs in resident rooms limited available space in resident rooms.<br><br>3.1-(19) | | | |
| K0062 SS=E | Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>Based on observation and interview, the facility failed to ensure a clearance of at least 18 inches was maintained below the level of sprinkler deflectors for sprinklers in 2 of 3 exit corridors and the kitchen cooler. NFPA 13, 1999 edition, at 5-5.5.2.1 says a continuous or noncontinuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray | K0062 | CORRECTIVE ACTIONThe cabinet in the Physical Therapy room was moved.IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESEmployees will be inserviced on the need to have clearance of 18 inches below each sprinkler. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will monitor compliance of 18 inch clearance below sprinklers three times per | 07/01/2011 |

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| | pattern from fully developing. This deficient practice could affect any residents using the exit corridors and 1 kitchen staff.<br><br>Findings include:<br><br>Based on observations with the maintenance director on 06/01/11 between 12:40 p.m. and 3:40 p.m., less than an eighteen inch clearance from sprinkler deflectors was maintained in Physical Therapy where a cabinet was six inches from the sprinkler deflector and the main dining room where vertical plastic sheeting was installed eight inches from two sprinkler heads and prevented coverage for the adjacent area they were designed to protect. The maintenance director agreed at the time of observations, the sprinkler head sprays could be affected by the obstructions.<br><br>3.1.19(b) | | week x 1 month, then one time per week x 5 months. Any problems identified during audits will be corrected immediately and Findings will be reported to the QA Committee. | |

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| K0076 SS=E | Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.<br>NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>Based on observation and interview, the facility failed to ensure 1 of 2 cylinders of nonflammable gases in the ante room separating the oxygen storage room from the corridor and resident shower room was properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 18 in the northwest smoke compartment.<br><br>Findings include: | K0076 | CORRECTIVE ACTIONAll oxygen cylinders have been correctly stored with support by use of chains. IDENTIFY OTHER RESIDENTS18 residents have the potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESStaff have been inserviced regarding the proper use of oxygen storage. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will monitor oxygen storage and report findings to the QA Committee. Oxygen storage will be monitored three times per week x 4 weeks, then one time per week x 5 months. All concerns will be corrected immediately and education provided. | 07/01/2011 |

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| | Based on observation with the maintenance director on 06/01/11 at 2:55 p.m., one oxygen e-cylinder was stored without support in the ante room to the 200 hall shower. The maintenance director said at the time of observation, the cylinders were left over and he knew they should have been supported.<br><br>3.1-19(b) | | | |
| K0130 SS=E | OTHER LSC DEFICIENCY NOT ON 2786<br><br>Based on record review, observation and interview; the facility failed to maintain 2 of 2 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows. NFPA 80, 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained | K0130 | CORRECTIVE ACTIONThe verticle rolling fire doors have been added to the inspection list with the fire system contractor.IDENTIFY OTHER RESIDENTSAll residents have potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESThe verticle rolling fire doors have been added to the inspection list with the fire system contractor. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will ensure inspection of the verticle rolling fire doors during the fire system contractor inspections. The results of the fire inspection will | 07/01/2011 |

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| | and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 20 or more residents in the main dining room.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 06/01/11 at 1:00 p.m., vertical rolling fire doors protected two service window openings between the kitchen and main dining room. A review of fire equipment inspection and testing reports on 06/01/11 at 1:30 p.m. did not include a report of testing for the rolling fire doors. The maintenance director said at the time of observation, he was unsure whether the doors were inspected and a immediate call placed to the fire system contractor produced no documentation of an inspection.<br><br>3.1-19(b) | | be reported to the QA Committee x 6 months. | |

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| K0143 SS=E | Transferring of oxygen is:<br><br>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;<br><br>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br><br>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfer sites was posted with a sign indicating oxygen transferring was taking place and provided with continuous mechanical ventilation to the outside. This deficient practice affects staff, visitors and 18 residents in the northwest smoke compartment.<br><br>Findings include:<br><br>Based on observation with the maintenance director on 06/01/11 at 3:05 p.m., four liquid oxygen supply containers and four oxygen e-cylinders were located in an | K0143 | CORRECTIVE ACTIONThe facility will provide a sign that will serve as notice that the room is used for transfilling portable oxygen tanks. The facility will ensure that a mechanical vent is in working order to provide continuous mechanical ventilation to the outside. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice. MEASURES/SYSTEMIC CHANGESStaff will be inserviced regarding the proper use of the oxygen room and that a sign is posted to serve as notice that it is used for transfilling oxygen. Staff will be inserviced that the same room is required to have continuous mechanical ventilation to the outside.MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will monitor | 07/01/2011 |

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| | oxygen supply storage room accessed by an ante room shared with the shower room. The physical plant director said the room was used for the transfilling of portable oxygen tanks. There was no sign to provide notice it was used for oxygen transfer. A mechanical vent was provided which the director of plant operations said at the time of observation, provided exhaust to the outside. It did not appear to be working. The maintenance director agreed.<br><br>3.1-19(b) | | that sign used for transfilling oxygen is properly posted and that continuous mechanical ventilation is in proper working order three times per week x 1 month, and one time per week x 5 months and report findings to the QA Committee. | |
| K0144 SS=F | Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency | K0144 | CORRECTIVE ACTIONFacility added an emergency shut off at a remote location. IDENTIFY OTHER RESIDENTSAll residents | 07/01/2011 |

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| | generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on interview on 06/01/11 at 1:10 p.m. with the maintenance director, he had no information as to when the emergency generator | | have the potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESAll staff will be inserviced regarding the location of the emergency generator shut off.MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will orient new employees to the emergency generator shut off. Concerns will be reported to the QA Commmittee monthly x 6 months. | |

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| | was installed. He said said at the time of record review, he didn't know if there was a remote emergency shut off for the emergency generator or the horsepower rating. Upon inspection of the generator and it's components on 06/01/11 at 2:10 p.m., a remote emergency shut off for the generator was located on the generator but not at a remote location.<br><br>3.1-19(b)<br><br>2. Based on interview and record review, the facility failed to provide complete test documentation for 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, the Standard for Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions and at a capacity not less than 50 percent | | | |

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| | of the total EPSS (Emergency Power Supply System load or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating, whichever load is greater, at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the Emergency Generator Test records with the maintenance director on 06/01/11 at 12:50 p.m., load test records for the past year did not include documentation of the generator load carried during the monthly test. The director of plant operations said at the time of interview, he was unsure of the actual percent load carried during testing. He said he didn't know how to make the calculation based on the documented readings taken during testing. No load transfer | | | |

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| | time was documented.<br><br>3.1-19(b)<br><br>3. Based on interview and record review, the facility failed to provide complete weekly inspection documentation for 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, 3-4.4.1.3 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than seven days. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the Emergency Generator Test records with the maintenance director on 06/01/11 at 12:50 p.m., weekly test records for the past year did not include | | | |

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| | documentation of weekly battery checks and the general condition of hoses, clamps, and cables. The director of plant operations said at the time of record review, the checks were made but not recorded.<br><br>3.1-19(b) | | | |
| K0154 SS=C | Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1<br>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 63 of 63 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire | K0154 | CORRECTIVE ACTIONFacility documentation of load does include generator load on a monthly basis. The surveyor was reviewing the weekly test. The monthly test was not provided to the surveyor at the time of survey in error. Facility has added documentation for load test weekly and monthly. Facility has added the general condition of hoses, clamps, and cables, to the weekly test records. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the alleged deficient practice. MEASURES/SYSTEMIC CHANGESThe forms used for the weekly generator test have been | 07/01/2011 |

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| | Protection Systems. NFPA 25, 11-5(d) requires the local fire department to be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also to be notified. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on review of the facility's policy and procedure book with the maintenance director on 06/01/11 at 1:55 p.m., the fire watch procedure for an out of service automatic sprinkler system was not complete. The procedures did not contain the telephone numbers for the local fire department or the Indiana State Department of Health. The procedure also did not contain statements that the facility's staff were to be trained and designated in regard to the fire watch plan. The maintenance director said at the time of the record review, he was not aware of the problem.<br><br>3.1-19(b) | | updated to include general condition of hoses, clamps, and cables. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations (DPO) or designee will monitor weekly and monthly Emergency Generator Test Records to ensure that generator load and condition of hoses, clamps, and cables are documented. The DPO will monitor forms one time per month x 6 months and will report findings to the QA Committee. | |

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| K0155 SS=C | Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8<br>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 63 of 63 residents in the event the fire alarm system has to be placed out of service for four hours within a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to | K0155 | CORRECTIVE ACTIONThe facility fire watch policy was updated to include telephone number for the local fire department and ISDH. The policy was also updated to include that the Director of Plant Operations (DPO) or designee will conduct the Fire Watch and will have no other responsibilities during the fire watch.IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice. MEASURES/SYSTEMIC CHANGESThe fire watch policy was updated. The DPO will include the fire watch policy to the annual Fire Safety inservice. MONITORING CORRECTIVE ACTIONThe DPO or designee will monitor the effectiveness of the fire watch policy and make changes as needed. The DPO or designee will report findings to the QA Committee one time per month for 6 months. | 07/01/2011 |

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| | alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of the facility's Emergency Fire Watch plan with the maintenance director on 06/01/11 at 1:55 p.m., the fire watch policy and procedure for an out of service automatic alarm system was not complete. The procedures did not contain the telephone numbers for the local fire department or the Indiana State Department of Health. The procedure also did not contain statements that the facility's staff were to be trained and designated in regard to the fire watch plan. The maintenance director said at the time of the record review, he was not aware of the problem.<br><br>3.1-19(b) | | | |

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